(2) Total inpatient census days means the total number of a hospital's inpatient census days during its fiscal year ending in the previous calendar year.

(3) Total Medicaid inpatient hospital payments means the total amount of Title XIX funds, excluding Medicaid disproportionate share funds, a hospital received for admissions during the latest available state fiscal year for inpatient services.

(4) Total operating costs means the total operating costs of a hospital during its fiscal year ending in the calendar year before the start of the federal fiscal year, according to the hospital's Medicare cost report (tentative, or final audited cost report, if available).

(5) Total state and local revenue means the total amount of state and local revenue a hospital received for inpatient care, excluding all Title XIX payments, during its fiscal year ending in the previous calendar year.

(6) Gross inpatient revenue means the amount of gross inpatient revenue (charges) reported by the hospital in the appropriate part of the Medicare cost report it submitted for its fiscal year ending in the previous calendar year.

(7) Total inpatient charity charges, excluding bad debt charges, means the total amount of the hospital's charges for inpatient hospital services attributed to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period. The total inpatient charges attributable to charity care does not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan); that is, reduction or discounts, in charges given to other third-party payers such as but not limited to HMOs, Medicare, or Blue Cross.

(8) A rural area is defined as an area outside a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget.

(9) Cost of services to uninsured patients are the inpatient and outpatient charges to patients who have no health insurance or other source of third party payment for services provided during the year, multiplied by the hospital's ratio of costs to charges (inpatient and outpatient), less the amount of payments made by or on behalf of those patients. Uninsured patients are patients who have no health insurance or other source of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment.

(10) Hospital specific limit is the sum of the following two measurements: (a) Medicaid shortfall; and (b) cost of services to uninsured patients.

(11) Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan.

(12) Cost-to-charge ratio (inpatient only) is the hospital's overall inpatient cost-to-charge ratio, as determined from its Medicare cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicare cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.

(13) Cost-to-charge ratio (inpatient and outpatient) is the hospital's overall cost-to-charge ratio, as determined from its Medicare cost report submitted for the fiscal year

ending in the previous calendar year. The latest available Medicare cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.

(14) Gross inpatient revenue is the amount of gross inpatient revenue (charges) reported by the hospital in the appropriate part of the Medicare cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicare cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.

(15) Adjusted hospital specific limit is a hospital specific limit trended forward to account for the inflation update factor since the base year.

(16) Bad debt charges are uncollectible inpatient and outpatient charges that result from the extension of credit. For purposes of Appendix 1, "bad debt charges" are used in the calculation of charges attributed to uninsured patients as defined in (b)(9), and are used only in the limited circumstances described in (g)(2).

(17) Inflation update factor is a general increase in prices as determined by the state. For additional information concerning the inflation update factor, see §(n)(2), page 8 of the Methods and Standards for Establishing Payment Rates--Inpatient Services, of this state plan.

(18) Medicaid inpatient utilization rate is the rate defined in §1923(b)(2) of the Social Security Act.

(19) Payments received from uninsured patients are those payments received from or on behalf of uninsured patients as defined in (b)(9).

(20) Charity charges are the total amount of hospital charges for inpatient and outpatient services attributed to charity care in a cost reporting period. These charges do not include bad debt charges, contractual allowances or discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid state plan); that is, reductions or discounts in charges given to other third party payers such as, but not limited to, health maintenance organizations, Medicare, or Blue Cross. Charity charges are used in the calculation of charges attributed to uninsured patients as defined in (b)(9), only in the limited circumstances described in (g)(2).

(21) Allowable cost is defined by the state using the same methods and procedures that are reflected in both the inpatient and outpatient sections of the currently approved state plan.

(22) Available fund for state mental and chest hospitals is the sum of 100 percent of their adjusted hospital specific limits.

(23) Available fund for the remaining hospitals is the total federal fiscal year cap (state disproportionate share hospital allotment) minus the available fund for state teaching hospitals minus the available fund for state mental and chest hospitals.

(c) The single state agency identifies the qualifying Medicaid disproportionate share providers from among the hospitals that meet the state's conditions of participation using the following formulas. Children's hospitals that meet all the requirements in (a) but do not otherwise qualify as disproportionate share hospitals are deemed disproportionate share hospitals.

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(1) A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals participating in the Medicaid program;

$$\frac{\text{Title XIX Inpatient Days}}{\text{Total Inpatient Census Days}}$$

OR

(2) For rural hospitals, a Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for all hospitals participating in the Medicaid program;

OR

(3) A low income utilization rate exceeding 25 percent. For a hospital, the low income utilization rate is the sum (expressed as a percentage) of the fractions calculated as follows:

(A) Total Medicaid inpatient payments paid to the hospital, plus the amount of revenue received directly from state and local governments, excluding all Title XIX payments, in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of state and local revenue) in the same cost reporting period multiplied by the hospital's inpatient cost to charge ratio for the same cost reporting period;

$$\frac{\text{Title XIX inpatient hospital payments + Total state/local revenue}}{\text{Gross Inpatient Revenue * Inpatient Cost to Charge Ratio}}$$

AND

(B) Total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources), excluding bad debt charges, in a cost reporting period, minus the amount of revenue for inpatient hospital services received directly from state and local governments, excluding all Title XIX payments, in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributable to charity care does not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan); that is, reductions or discounts in charges given to other third-party payers such as but not limited to HMOs, Medicare, or Blue Cross.

$$\frac{\text{Total inpatient charity charges - Total state/local revenue}}{\text{Gross Inpatient Revenue}}$$

OR

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(4) Total Medicaid inpatient days at least one standard deviation above the mean Medicaid inpatient days for all hospitals participating in the Medicaid program.

(d) The single state agency determines Medicaid disproportionate share status in the following ways:

(1) The single state agency arrays each hospital's Medicaid inpatient utilization rate in descending order. The single state agency first selects hospitals, meeting the requirements in (a) above, whose Medicaid inpatient utilization rates are at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals participating in the Medicaid program. The state considers these hospitals to be Medicaid disproportionate share hospitals.

(2) The single state agency arrays each rural hospital's Medicaid inpatient utilization rate in descending order. The single state agency then selects rural hospitals, meeting the requirements in (a) above, whose Medicaid inpatient utilization rate is above the mean Medicaid inpatient utilization rate for all hospitals participating in the Medicaid program. The state considers these hospitals to be Medicaid disproportionate share hospitals.

(3) The single state agency then arrays each remaining hospital's low income utilization rate in descending order. The single state agency selects hospitals, meeting the requirements in (a) of this state plan, whose low income utilization rates are greater than 25 percent. The state considers these hospitals to be Medicaid disproportionate share hospitals.

(4) Finally, the single state agency arrays each remaining hospital's total Medicaid inpatient days in descending order. The single state agency selects hospitals, meeting the requirements in (a) of this state plan, whose total inpatient Medicaid days is at least one standard deviation above the mean Medicaid inpatient days for all hospitals participating in the Medicaid program. The state considers these hospitals to be Medicaid disproportionate share hospitals.

(e) The single state agency then reimburses Medicaid disproportionate share hospitals on a monthly basis. Monthly payments equal one-twelfth of annual payments unless it is necessary to adjust the amount because payments are not made for a full 12-month period, to comply with the annual state disproportionate share hospital allotment, or to comply with other state or federal disproportionate share hospital program requirements.

Prior to the start of the next state fiscal year, the single state agency determines the size of the available funds to reimburse disproportionate share hospitals for the next state fiscal year, which begins each September 1. The funds available to reimburse the state chest hospitals and state mental hospitals equal the total of their adjusted hospital specific limits. The available fund for the remaining hospitals equals the lesser of the funds remaining in the state's annual disproportionate share hospital allotment or the sum of qualifying hospitals' adjusted hospital specific limits.

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Payments are made in the following manner, unless the state determines the hospital's proposed reimbursement has exceeded its adjusted hospital specific limit:

(1) A state chest hospital (facility of the Texas Department of Health) or a state mental hospital (facility of the Texas Department of Mental Health and Mental Retardation) that meets the requirements for disproportionate share status and provides inpatient psychiatric care or inpatient hospital services receives annually 100 percent of its adjusted hospital specific limit.

(2) For the remaining hospitals, payments are based on both weighted inpatient Medicaid days and weighted low income days. The single state agency weights each hospital's total inpatient Medicaid days and low income days by the appropriate weighting factor. The state defines a low income day as a day derived by multiplying a hospital's total inpatient census days from its fiscal year ending in the previous calendar year by its low income utilization rate. Hospital districts and city/county hospitals with greater than 250 licensed beds in the state's largest MSAs would receive weights based proportionally on the MSA population according to the 1990 United States census. MSAs with populations greater than or equal to 150,000, according to the 1990 census, are considered as the "largest MSAs." Children's hospitals also receive weights because of the special nature of the services they provide. All other hospitals receive weighting factors of 1.0. The inpatient Medicaid days of each hospital are based on the latest available state fiscal year data for patients entitled to Title XIX benefits. The available fund is divided into two parts. Two-thirds of the available fund reimburse each qualifying hospital on a monthly basis by its percent of the total inpatient Medicaid days. One-third of the available fund reimburses each qualifying hospital by its percent of the total low income days.

Reimbursement for the remaining hospitals is determined monthly as follows:

(1) The single state agency determines the average monthly number of weighted Medicaid inpatient days and weighted low income days of each qualifying hospital.

(2) A qualifying hospital receives a monthly disproportionate share payment based on the following formula:

$$\left(\frac{2}{3} * \text{Available Fund for Remaining Hospitals} * \frac{\text{Hospital's Avg. Mo. Title XIX Days} * \text{Weight}}{\text{Total Avg. Mo. Weighted Medicaid Days}}\right)$$

+

$$\left(\frac{1}{3} * \text{Available Fund for Remaining Hospitals} * \frac{\text{Hospital's Avg. Mo. Low Income Days} * \text{Weight}}{\text{Total Avg. Mo. Weighted Low Income Days}}\right)$$

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(f) The specific weights for certain hospital districts and children's hospitals are as follows:

(1) Children's hospitals are weighted at 1.25.

(2) MSAs with populations greater than or equal to 150,000 and less than 300,000 are weighted at 2.25.

(3) MSAs with populations greater than or equal to 300,000 and less than 1,000,000 are weighted at 2.50.

(4) MSAs with populations greater than or equal to 1,000,000 and less than 3,000,000 are weighted at 2.75.

(5) MSAs with populations greater than or equal to 3,000,000 are weighted at 3.25

All MSA population data are from the 1990 United States census.

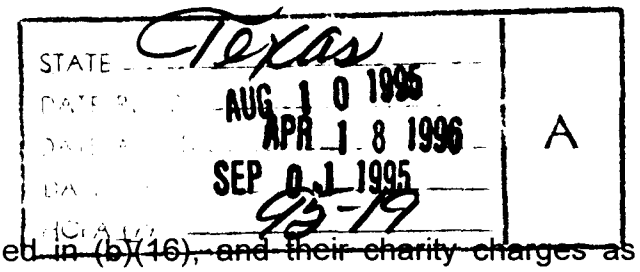
(g) The state or its designee determines the hospital specific limit for each disproportionate share hospital. This limit is the sum of a hospital's Medicaid shortfall, as defined in (b)(11), and its cost of services to uninsured patients, as defined in (b)(9), multiplied by the appropriate inflation update factor, as provided for in (h).

(1) The Medicaid shortfall includes total Medicaid billed charges and any Medicaid payment made for the corresponding inpatient and outpatient services delivered to Texas Medicaid clients, as determined from the hospital's fiscal year claims data, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, patients whose spell of illness claims were exhausted, or payments were denied due to late filing. (See definition for "Medicaid shortfall.")

The total Medicaid billed charges for each hospital are converted to cost, utilizing a calculated cost-to-charge ratio (inpatient and outpatient). The state or its designee determines that ratio by using the hospital's Medicare cost report that was submitted for the fiscal year ending in the previous calendar year. The state or its designee uses the latest available Medicare cost report in the absence of the Medicare cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part I, Column 25 and total charges from Worksheet C Part I, Column 6. The ratio is the total cost divided by the total gross patient charges.

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the fiscal year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges from reporting hospitals are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine the cost.

Hospitals that do not respond to the survey, or that are unable to determine accurately the charges attributed to patients without insurance, shall have their bad debt charges



as defined in (b)(16), and their charity charges as defined in (b)(20), reduced by a percentage derived from a representative sample of hospitals to be determined annually by the state or its designee. The state derives the percentages using the following formula; for each specific category of hospitals listed in (g)(2)(A), the state sums the total amount of charges for patients without health insurance or other third party payments. For each specific category of hospitals listed in (g)(2)(A), the state sums the charity and bad debt charges. For each specific category of hospitals listed in (g)(2)(A), the state then divides the charges for patients without health insurance or other third party payments by the sum of charity and bad debt charges. The state then uses the resulting ratio for each specific category of hospitals listed in (g)(2)(A) in the following manner. Individual hospitals that do not respond to the survey, or that are unable to accurately determine the charges attributed to patients without insurance have their hospital's individual sum of bad debt and charity charges multiplied by the appropriate ratio for the specific hospital category. After the state has calculated a value for the charges for patients without health insurance or other source of third party payment for each individual hospital, the state multiplies each hospital's calculated value by that hospital's cost-to-charge ratio (inpatient and outpatient) to obtain the proxy cost of services delivered to uninsured patients at each hospital.

(A) The representative sample of hospitals is one of the following specific categories of hospitals: urban public, other urban, rural, state operated psychiatric and non-state psychiatric. In the event that less than 20 percent of the hospitals in a specific category provide data to the department, the state or its designee uses the overall ratio calculated for all responding hospitals. The state or its designee creates additional categories, by submitting a state plan amendment, as it deems appropriate for the economic and efficient operation of the Medicaid disproportionate share hospital program.

(B) After the state or its designee determines each disproportionate share hospital's cost of services to patients who have no health insurance or source of third party payments for services provided during the year, the state subtracts from each hospital's cost of services the amount of payments made by or on behalf of those patients who have no health insurance or source of third party payments for services provided during the year.

(h) The state or its designee trends each hospital's "hospital specific limit" calculated from its historical base period cost report from (g) of this state plan to the state's fiscal year disproportionate share program. For hospitals without full 12-month fiscal year cost reports, the state or its designee annualizes the cost to calculate the hospital specific limit. The state or its designee uses the inflation update factor, as defined in (b)(17), in calculating the adjusted hospital specific limit. The state or its designee calculates the number of months from the mid-point of the hospital's cost reporting period to the mid-point of the state fiscal year disproportionate share program. The state or its designee then multiplies the portion of the hospital's cost report year occurring in the state fiscal year by the inflation update factor used for each state fiscal year in the calculation of

hospital reimbursement rates for each state fiscal year. The product of these calculations is multiplied by each hospital's hospital specific limit to obtain each hospital's adjusted hospital specific limit.

(i) The state or its designee compares the projected payment for each disproportionate share hospital, as determined by (e) and (f), with its adjusted hospital specific limit, as determined by (g) and (h). If the hospital's projected payment is greater than its adjusted hospital specific limit, the state or its designee reduces the hospital's payment to its adjusted hospital specific limit.

(j) If there are disproportionate share hospital funds left in the available fund for the remaining hospitals, because some hospitals have had their disproportionate share hospital payments reduced to their adjusted hospital specific limits, the state distributes the excess funds according to the provisions in this section. For hospitals whose projected disproportionate share hospital payments are less than their adjusted hospital specific limits, the state or its designee does the following:

(1) calculate the difference between its adjusted hospital specific limit and its projected disproportionate share hospital payment;
(2) add all of the differences from (j)(1);
(3) calculate a ratio for each hospital by dividing the difference from (j)(1) by the sum for (j)(2); and
(4) multiply the ratio from (j)(3) by the remaining available fund.

Remaining Available Fund * (Hospital's Adjusted Limit - Hospital's Projected Disproportionate Share Payment / Total)

Only those hospitals that are below their adjusted hospital specific limits are eligible to participate in this distribution. The disproportionate share hospital funds remaining in the available fund are distributed to the hospitals that have not already reached their adjusted hospital specific limits. Each hospital's total disproportionate share payment (including the redistribution of excess funds) cannot exceed its adjusted hospital specific limit.

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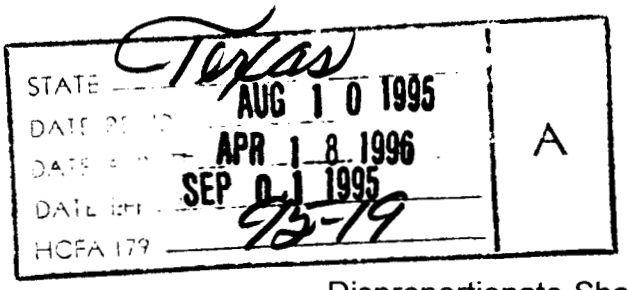

Disproportionate Share Program
for State-Owned Teaching Hospitals

(a) Effective December 12, 1990, a hospital owned and operated by a state university or other agency of the state is eligible for disproportionate share reimbursement. A state-owned teaching hospital is a hospital owned and operated by a state university or other agency of the state.

(b) Each hospital must have a Medicaid inpatient utilization rate as defined in §1923(b)(2), at a minimum, of one percent in accordance with §§1923(d)(3) and 1923(e)(2)(C) of the Social Security Act.

(c) To qualify for disproportionate share payments, each hospital must have at least two physicians (M.D. or D.O.), with staff privileges at the hospital, who have agreed to provide nonemergency obstetrical services to Medicaid clients. The two-physician requirement does not apply to hospitals whose inpatients are predominantly under 18 years old or that did not offer nonemergency obstetrical services to the general population as of December 22, 1987.

(d) For purposes of this state plan:

(1) Total Medicaid inpatient days means the total number of billed Title XIX inpatient days based on the latest available state fiscal year data for patients eligible for Title XIX benefits. Total Medicaid inpatient days includes days that were denied payment for reasons other than eligibility. Included are inpatient days of care provided to patients eligible for Medicaid at the time the service was provided, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, claims for patients whose spell of illness limits are exhausted, or claims that were filed late. The term excludes days attributable to Medicaid patients between the ages of 21 and 65 who live in an institution for mental diseases. The term includes days attributable to individuals eligible for Medicaid in other states.

(2) Total inpatient census days means the total number of a hospital's inpatient census days during its fiscal year ending in the previous calendar year.

(3) Cost of services to uninsured patients are the inpatient and outpatient charges to patients who have no health insurance or other source of third party payment for services provided during the year, multiplied by the hospital's ratio of costs to charges (inpatient and outpatient), less the amount of payments made by or on behalf of those patients. Uninsured patients are patients who have no health insurance or other source of third party payments for services provided during the year. Uninsured patients include

those patients who do not possess health insurance that would apply to the service for which the individual sought treatment. Cost of services does not include any bad debt charges.

(4) Hospital specific limit is the sum of the following two measurements: (a) Medicaid shortfall; and (b) cost of services to uninsured patients.

(5) Medicaid shortfall is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan.

(6) Cost-to-charge ratio (inpatient and outpatient) is the hospital's overall cost-to-charge ratio, as determined from its Medicare cost report submitted for the fiscal year ending in the previous calendar year. The latest available Medicare cost report is used in the absence of the cost report for the hospital's fiscal year ending in the previous calendar year.

(7) Adjusted hospital specific limit is a hospital specific limit trended forward to account for the inflation update factor since the base year.

(8) Inflation update factor is a general increase in prices as determined by the state. For additional information concerning the inflation update factor, see §(n)(2), page 8 of the Methods and Standards for Establishing Payment Rates--Inpatient Services, of this state plan.

(9) Medicaid inpatient utilization rate is the rate defined in §1923(b)(2) of the Social Security Act.

(10) Payments received from uninsured patients are those payments received from or on behalf of uninsured patients as defined in (d)(3).

(11) Charity charges are the total amount of hospital charges for inpatient and outpatient services attributed to charity care in a cost reporting period, as reported on the state teaching hospitals' annual financial reports, for use only in the calculation of the disproportionate share hospital payment under section 1923(e).

(12) Allowable cost is defined by the state using the same methods and procedures that are reflected in both the inpatient and outpatient sections of the currently approved state plan.

(13) Available fund for state teaching hospitals is the total amount of funds that may be reimbursed to the state teaching hospitals as determined below.

(e) The single state agency reimburses state-owned teaching hospitals on a monthly basis from the available fund for state teaching hospitals. Monthly payments equal one-twelfth of annual payments unless it is necessary to adjust the amount because payments are not made for a full 12-month period, to comply with the annual state disproportionate share hospital allotment, or to comply with other state or federal disproportionate share hospital program requirements.

Prior to the start of the next federal fiscal year, the single state agency determines the size of the fund to reimburse state-owned teaching hospitals for the next federal fiscal year. The available fund to reimburse the state teaching hospitals equals the total of their

disproportionate share hospital payments, as determined below:

(1) A state teaching hospital will receive a monthly disproportionate share payment based on the following formula:

$$\frac{\text{Monthly Charity Charges of the State-Owned Teaching Hospital}}{\text{Total Monthly Charity Charges of All State-Owned Teaching Hospitals}} \times \text{Available Fund} =$$

(2) Under the requirements of section 1923(g), if the adjusted hospital specific limit for a state teaching hospital is less than the formula above, a state teaching hospital will receive 100 percent of its adjusted hospital specific limit, instead of the amount determined under (1) above.

(f) The state or its designee determines the hospital specific limit for each disproportionate share hospital. This limit is the sum of a hospital's Medicaid shortfall, as defined in (d)(5), and its cost of services to uninsured patients as defined in (d)(3), multiplied by the appropriate inflation update factor, as provided for in (g).

(1) The Medicaid shortfall includes total Medicaid billed charges and any Medicaid payments made for the corresponding inpatient and outpatient services delivered to Texas Medicaid clients, as determined from the hospital's fiscal year claims data, regardless of whether the claim was paid. Examples of these denied claims include, but are not limited to, patients whose spell of illness claims were exhausted, or payments were denied due to late filing. (See definition of "Medicaid shortfall.)

The total billed Medicaid charges for each hospital are converted to cost, utilizing a calculated cost-to-charge ratio (inpatient and outpatient). The state or its designee determines that ratio by using the hospital's Medicare cost report that was submitted for the fiscal year ending in the previous calendar year. The state or its designee uses the latest available Medicare cost report in the absence of the Medicare cost report submitted in the fiscal year ending in the previous calendar year. To determine the cost-to-charge ratio (inpatient and outpatient) for each hospital, the state or its designee uses the total cost from Worksheet B, Part 1, Column 25 and total charges from Worksheet C, Part 1, Column 6. The ratio is the total cost divided by the total gross patient charges.

(2) The state or its designee determines the cost of services to patients who have no health insurance or source of third party payments for services provided during the year for each hospital. Hospitals are surveyed each year to determine charges that can be attributed to patients without insurance or other third party resources. The charges are multiplied by each hospital's cost-to-charge ratio (inpatient and outpatient) to determine the cost.

After the state or its designee determines each disproportionate share hospital's cost of services to patients who have no health insurance or source of third party payments for services provided during the year, the state subtracts from each hospital's cost of services the amount of payments made by or on behalf of those patients who

have no health insurance or source of third party payments for services provided during the year.

(g) The state or its designee trends each hospital's "hospital specific limit" calculated from its historical base period cost report from (f) of this state plan to the state's fiscal year disproportionate share program. For hospitals without full 12-month fiscal year cost reports, the state or its designee annualizes the cost to calculate the hospital specific limit. The state or its designee uses the inflation update factor, as defined in (d)(8), in calculating the adjusted hospital specific limit. The state or its designee calculates the number of months from the mid-point of the hospital's cost reporting period to the mid-point of the state fiscal year disproportionate share program. The state or its designee then multiplies the portion of the hospital's cost report year occurring in the state fiscal year by the inflation update factor used for each state fiscal year in the calculation of hospital reimbursement rates for each state fiscal year. The product of these calculations is multiplied by each hospital's hospital specific limit to obtain each hospital's adjusted hospital specific limit.

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